General Assembly

Committee Bill No. 6550

January Session, 2015

LCO No. **5661**

Referred to Committee on HUMAN SERVICES

Introduced by:
(HS)

AN ACT CONCERNING MEDICAID PROVIDER AUDITS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 17b-99 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(d) The Commissioner of Social Services, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider that participates as a provider of services in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall conduct any such audit in accordance with the provisions of this subsection. For purposes of this subsection <u>"audit look-back period" means a period of time not to exceed thirty-six months from date of payment of a provider's claim;</u> "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn; "provider" means a person, public agency, private agency or

proprietary agency that is licensed, certified or otherwise approved by the commissioner to supply services authorized by the programs set forth in said chapters; "statistically valid sampling methodology" means a methodology that is validated by a statistician or person with equivalent experience as having a confidence level of ninety-five per cent or greater; and "universe" means a defined population of claims submitted by a provider during a specific time period.

(1) Not less than thirty days prior to the commencement of any such audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall provide written notification of the audit and the statistically valid sampling methodology to be used to such provider, unless the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider makes a good faith determination that (A) the health or safety of a recipient of services is at risk; or (B) the provider is engaging in vendor fraud. A copy of the regulations established pursuant to subdivision (11) of this subsection shall be appended to such notification.

(2) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which providers shall be subject to audits, the Commissioner of Social Services **[**may**]** shall give consideration to the history of a provider's compliance in addition to other criteria used to select a provider for an audit.

(3) A finding of overpayment or underpayment to a provider in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a provider for which rates are established pursuant to section 17b-340, shall not be based on extrapolation of a clerical error as described in subdivision (2)

of this subsection unless (A) there is a determination of sustained or high level of payment error involving the provider, (B) documented educational intervention has failed to correct the level of payment error, or (C) the **[**value of the claims in aggregate exceeds two hundred thousand dollars on an annual basis**]** provider's error rate exceeds ten per cent in an audit performed with a statistically valid sampling methodology and the provider has a history of at least one previous overpayment error identified in an audit. An overpayment assessment based on extrapolation of a clerical error shall not exceed by more than three times the dollar amount of the clerical error unless there is a determination of a sustained or high level of provider payment error or if a documented educational intervention offered to the provider has failed to correct the level of payment error. Such determination may be made by means that include, but are not limited to, (i) audit history of a provider, (ii) analysis of additional samples using a statistically valid sampling methodology, (iii) information from law enforcement investigations, and (iv) allegations of wrongdoing by current or former employees of a provider.

(4) A provider, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit. Such documentation may include evidence that clerical errors concerning payment and billing resulted from a provider's transition to a new payment or billing service. The commissioner may permit a provider to correct minor clerical errors prior to a final audit determination. The commissioner shall not issue an overpayment assessment to a provider or attempt to recoup an overpayment based on an extrapolation when the provider presents credible evidence that an error by the department caused the payment error.

(5) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant

to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall produce a preliminary written report concerning any audit conducted pursuant to this subsection, and such preliminary report shall be provided to the provider that was the subject of the audit not later than sixty days after the conclusion of such audit. If a preliminary finding of an overpayment based on extrapolation of a clerical error exceeds two hundred thousand dollars, the commissioner shall schedule a conference with the provider not later than thirty days after the conclusion of such audit. Not later than thirty days after such conference, a provider may conduct an independent audit at the provider's expense of (A) all of the claims included in the universe subject to findings based on extrapolation, or (B) a second sample twice the size of the original identified by the department using the same statistically valid sampling methodology. The department may reject any audit not based on statistically valid sampling methodology or not in compliance with state or federal law. The commissioner shall amend the preliminary report in accordance with any verified evidence that initial findings were incorrect.

(6) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall, following the issuance of the preliminary report pursuant to subdivision (5) of this subsection, hold an exit conference with any provider that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such provider may present evidence at such exit conference refuting findings in the preliminary report if such provider has not already done so pursuant to subdivision (5) of this subsection.

(7) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider,

shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the provider that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subdivision (6) of this subsection, unless the commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, agrees to a later date or there are other referrals or investigations pending concerning the provider.

(8) Any provider aggrieved by a decision contained in a final written report issued pursuant to subdivision (7) of this subsection may, not later than thirty days after the receipt of the final report, request, in writing, a review on all items of aggrievement. Such request shall contain a detailed written description of each specific item of aggrievement. The designee of the commissioner who presides over the review shall be impartial and shall not be an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with which the commissioner contracts for the purpose of conducting an audit of a service provider. Following review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision.

(9) A provider may appeal a final decision issued pursuant to subdivision (8) of this subsection **[**to the Superior Court**]** in accordance with the provisions of chapter 54. In the case of an extrapolated clerical error, the department shall not subject the provider to an overpayment assessment or recoupment order that exceeds the amount of the original error until all administrative appeals have been exhausted pursuant to chapter 54.

(10) The provisions of this subsection shall not apply to any audit conducted by the Medicaid Fraud Control Unit established within the Office of the Chief State's Attorney.

(11) The commissioner shall adopt regulations, in accordance with

the provisions of chapter 54, to carry out the provisions of this subsection. **[**and to ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process.**]** The regulations shall (A) state the statistically valid sampling methodologies to be used, (B) establish the minimum qualifications of the statistician or person with equivalent experience who shall validate such methodologies, (C) limit audits to only paid claims and, whenever possible, isolate unique or rare claims from others included in a sample subject to extrapolation, (D) apply a median rather than an average in any extrapolation involving claims with multiple services, (E) limit the audit look-back period in accordance with this subsection, and (F) set forth the administrative appeal procedures in a manner that is consistent with the provisions of chapter 54. The commissioner shall provide free training to providers on how to enter claims to avoid clerical errors and shall post information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than February 1, 2015, the commissioner shall establish and publish on the department's Internet web site audit protocols to assist the Medicaid provider community in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish audit protocols for specific providers or categories of service, including, but not limited to: **[**(A)**]** (i) Licensed home health agencies, **[**(B)**]** (ii) drug and alcohol treatment centers, **[**(C)**]** (iii) durable medical equipment, **[**(D)**]** (iv) hospital outpatient services, **[**(E)**]** (v) physician and nursing services, **[**(F)**]** (vi) dental services, **[**(G)**]** (vii) behavioral health services, **[**(H)**]** (viii) pharmaceutical services, and **[**(I)**]** (ix) emergency and nonemergency medical transportation services. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, has on staff or consults with, as needed, a medical or dental

professional who is experienced in the treatment, billing and coding procedures used by the provider being audited.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2015*	17b-99(d)

Statement of Purpose:
To ensure fairness in audits of Medicaid providers.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

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H.B. 6550